

Athletes Name: _____ Graduation Year: _____ Age: _____ Height: _____

PARENT/GUARDIAN TO COMPLETE

MEDICAL HISTORY

1. Have you ever had, or have you now... (circle at the left of each item)

YES or NO	Concussions or ever knocked out (How many? _____)	YES or NO	Epilepsy or fits
YES or NO	Scarlet Fever	YES or NO	Frequent trouble sleeping
YES or NO	Rheumatic Fever	YES or NO	Excessive worry
YES or NO	Swollen or painful joints	YES or NO	Loss of memory or amnesia
YES or NO	Frequent or severe headaches	YES or NO	Nervous trouble of any sort
YES or NO	Dizziness or fainting spells	YES or NO	Abnormal growth, cyst, cancer
YES or NO	Eye trouble	YES or NO	Hernia
YES or NO	Ear, nose or throat trouble	YES or NO	Appendicitis
YES or NO	Chronic or frequent colds	YES or NO	Frequent or painful urination
YES or NO	Severe tooth or gum trouble	YES or NO	Blood in urine
YES or NO	Sinusitis	YES or NO	Sugar or albumin in urine
YES or NO	Tuberculosis (or lived w/person with TB)	YES or NO	Boils
YES or NO	Soaking sweats (night sweats)	YES or NO	Recent gain or loss of weight
YES or NO	Shortness of breath	YES or NO	Arthritis or rheumatism
YES or NO	Pain or pressure in chest	YES or NO	Painful or "trick" shoulder/elbow
YES or NO	Chronic cough	YES or NO	Hay fever/allergies
YES or NO	Palpitation or pounding heart	YES or NO	Asthma – inhaler type: _____
YES or NO	Cramps in your legs	YES or NO	Heart murmur or abnormality
YES or NO	Frequent indigestion	YES or NO	Broken bones: _____
YES or NO	Stomach, liver or intestinal trouble	YES or NO	Sprains: _____
YES or NO	Jaundice	YES or NO	Taking medications: _____
YES or NO	Any reaction to serum, drug, ect. (which _____)	YES or NO	Relatives under age 50 who have heart trouble
YES or NO	"Trick" or locked knee	YES or NO	Worn glasses
YES or NO	Foot trouble	YES or NO	Worn a brace or back support
YES or NO	Paralysis (including infantile)	YES or NO	Coughed up blood
		YES or NO	Bled excessively after a tooth extraction or operation

2. Immunizations

Date of last booster

Are you (check one)

Tetanus

_____ right handed

Hepatitis B

_____ left handed

MMR

3. Circle one of each – yes or no (each item marked "yes" must be fully explained in space at right)

YES or NO Have you had or been advised to have an operation? _____

YES or NO Have you had an illness or injury other than those already noted? _____

YES or NO Have you consulted or been treated by clinics, physicians, healers, or other practioners in the past five years? _____

4. Parental Permission: I authorize the doctor, hospital, or clinic above to furnish the transcript of my son's/daughter's medical record and hereby give my permission for him/her to participate in _____.

Parent Signature

Date

Student Signature

Date

Do you have any specific concerns or questions regarding any of your son's/daughter's sport related injuries? _____

South Whidbey High School Fax #: (360) 221-5797

Home Address (address, city, zip code)

Examining Facility/Examiner	Date of Exam
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Normal		Abnormal	
	1. Head, neck, scalp		
	2. Nose & throat		
	3. Ears – ear drums		
	4. Eyes		
	5. Heart & lungs		
	6. Abdomen (hernia)		
	7. Upper Extremities		
	8. Lower Extremities		
	9. Spine, other musculo-skeletal		
	10. Skin, Lymphatics		
	11. Neuralgic (equilibrium)		

LABORATORY FINDINGS

a. Specific Gravity _____ Hematocrit _____ (n1 = male 43; female 41)

b. Protein _____

c. Glucose _____

d. Blood _____

MEASUREMENTS AND OTHER FINDINGS

Height: _____ Weight: _____ Build _____ Blood Pressure (arm at heart level) _____
 _____ Post exercise Heart ü _____
 _____ Lungs ü _____
 % _____ Pulse: _____

Summary of Defects & Diagnosis

Recommendations – further specialist examinations indicated (specify)

q is qualified for soccer, x-country, football, basketball, golf, wrestling, volleyball, track, tennis, swimming
q is **not** qualified for ALL SPORTS

q THIS PHYSICAL IS GOOD FOR 1 YEAR **q THIS PHYSICAL IS GOOD FOR 2 YEARS**

<i>Typed or printed name of Examiner</i>	<i>Examiner's Signature</i>	<i>Date</i>
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